STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155694	A. BUILDING 00 B. WING	09/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETZ NURSING HOME	116 BETZ RD AUBURN, IN46706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: September 6, 7, 8, 9, 2011. Facility number: 000306 Provider number: 155694 AIM number: 100273860 Survey team: Tim Long, RN, TC Julie Wagoner, RN Christine Fodrea, RN Census bed type: SNF/NF: 93 Total: 93 Census payor type: Medicare: 5 Medicaid: 51 Other: 37 Total: 93 Sample: 19 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on September 14, 2011 by Bev Faulkner, RN	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to timely investigate and report of a possible incident of resident abuse for one (#22) of two incidents reviewed in a sample of nineteen. Findings include: On 9/9/11 at 10:00 A.M., review of the Resident Council minutes from 4/25/11, under new business, it was noted Resident #22 stated "she requested pancake syrup from a CNA on her wing and the CNA responded very angrily and never brought her the syrup." The administrator signed the resident council minutes on 4/25/11 indicating she read and reviewed the minutes. An interview with the Director of Nursing (DN) and the Administrator on 9/9/11 at 12:15 P.M., indicated a resident/family concern/grievance for was filled out by her following the incident on 4/25/11. Review of the form indicated under section 1: nature of concern: "CNA spoke harshly in response to" Resident #22's "request for syrup." Under section 2 on 4/26/11: "All concern must be referred to the Department Head for Review.	F0226	A. Resident #22 was re-interviewed by DNS. Resident stated the CNA was not rude or mean to her when she had asked for syrup on 4/25/11. The resident states that her feelings were hurt because the aide seemed to be rushed and brushed her off. The CNA was provided with 1:1 educations on approach and communication with residents by the DNS on 4/26/11. ISDH was notified on 9/9/2011 and investigation was reviewed by ISDH surveyors during the annual survey on 9/9/11B. All residents have the potential to be affected by this deficient practice. Other residents were interviewed regarding the communication from the CNA. None of the residents that were interviewed verbalized any concerns and that they had not been spoken harshly or treated rudely by the CNA.An all staff in-service was given by the Staff Development Coordinator and DNS on 9/20/11 in regards to abuse: approach to the residents, taking time to talk with them and answering them in a calm, not hurried voice. Staff was educated that all abuse allegations will be investigated and reported to the ISDH.C. All staff in-service will be conducted on abuse, allegation of abuse,	10/09/2011

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	Department Head review and action taken "it was noted the DN spoke to CNA #9: "resident feels that CNA spoke harsh to her when asking for pancake syrup. CNA was instructed to apologize to resident though CNA states she didn't feel she was harsh." Under section 3 on 4/26/11: "Follow up must be made with individual who voiced/wrote the concern" it was noted CNA "apologized to resident and explained to resident she didn't mean to sound cross or come across harsh. Resident accepted apology." The resident/family concern/grievance form was signed by the administrator on 4/26/11. An Interview with the DN on 9/9/11 at 12:15 P.M., indicated she did not think the incident on 4/26/11 needed to be investigated or reported as an allegation of possible verbal abuse at the time the incident was first reported to her . An interview with the DN on 9/9/11 at 1:15 P.M., indicated an abuse investigation had been started on 9/9/11 at 1:15 P.M., concerning the incident with Resident #22 on 4/25/11. An interview with the DN on 9/9/11 at 3:00 P.M., indicated the abuse investigation had been completed and concluded no verbal abuse occurred. The incident was reported to the ISDH.		communication and customer service routinely given by the Staff Development Coordinator.The Activity Director will address any concerns that the residents h ave on a monthly basis and druing resident council and the Activity Staff have been instructed to report any alleged abuse issues to the DNS and the ED immediately. If there are any concerns that are alleged abuse, they will be investigated immediately by the DNS and or ED. Customer Care rounds will be conducted by the Department head or designee daily to include monitoring for inappropriate staff to resident interaction.D. An Abuse Prohibition and Investigation CQI tool will b e completed by Social Services to ensure all allegation of abuse is investigated. The tool will be utilized weekly x 4 weeks, then monthly x 2 months and quarterly thereafter. If the threshold is not met, an action plan will be develped. Date will be submitted to the CQI committee for review and follow-up any non compliance may result in disciplinary action to including termination. The DNS/ED or designee will be responsible to program compliance. Addendum 10/5/11 F-226: A revised CQI monitoring tool will be implemented & includes timely reporting to the ISDH & others as required. If threshold of 90% is not met; an action plan will be	

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	A review of the facility policy "Abuse prohibition, report, and investigation policy and procedure," dated February 2010, indicated under definitions of abuse, verbal abuse: "defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to resident or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples would include, but are not limited to: threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family member again; or scolding and/or speaking to them in harsh voice tones." Under Policy/Procedure: number 5: "All abuse allegations/abuse must be reported tot the Executive Director immediately, and to the resident's representative (sponsor, responsible party) within 24 hours of the report. Failure to report will result in disciplinary action, up to and including immediate termination." Number 6: "The Executive Director is the designated individual responsible for coordinating all efforts in the investigation of abuse allegations, and for assuring that all policies and procedures are followed. In the absence of the Executive Director, this responsibility will be delegated to the Director of Nursing		written/implemented by the DNS/ADNS.	

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	Services." Number 7: "The Executive Director/designee will report all unusual occurrences, which include abuse, within 24 hours of discovery, to the Long Term Care Division of the Indiana State Department of Health. Upon completion of the investigation, which must occur within 5 working days of the reporting of an occurrence, a report of the investigation must be forwarded to the Long Term Care Division of the Indiana State Department of Health." 3.1-28(a)			
F0281 SS=D	The services provided or arranged by the facility must meet professional standards of quality. Based on observation, record review, and interview, the facility failed to ensure 1 of 3 nursing staff members (LPN #6) observed administering medications followed administration guidelines and professional standards regarding Novolog insulin administration for 1 of 2 residents observed receiving insulin during the medication pass (Resident #52) in a sample of 19. Finding includes:	F0281	A. Physician was notified of administration guidelines for Novolog insulin and an order was obtained to change the time of administration of Novolog insulin to be administered following accuchecks. The accuchecks will be completed 30 minutes prior to meals for resident #52.B. Residents who receive Novolog insulin have the potential to be affected by this deficient practice. An audit of all resident medication administration records will be done to identify residents who receive Novolog insulin. The	10/09/2011

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	1. On 09/08/11 at 11:00 A.M., LPN #6 was observed to obtain Resident #52's blood glucose level. The resident's blood glucose level was noted to be 167. On 09/08/11 at 1:07 P.M., LPN #6 was noted to administer Novolog insulin to Resident #52. The resident received his noon meal at 1:20 P.M. The exact amount of insulin was not determined by observation. Interview with LPN #6 on 09/08/11 at 2:00 P.M., regarding the insulin administration indicated she had given the resident his routine Novolog insulin and the additional units determined by the sliding scale orders. She indicated the resident's blood glucose level she had obtained prior to the insulin administration had been 167 and the resident had received 2 units of Novolog along with his 17 units of routinely scheduled insulin. On 09/09/11 at 12:11, LPN #6 obtained Resident #52's blood glucose level. The resident's blood glucose level was noted to be 216. At 12:28 P.M., LPN #6 administered a total of 21 units of Novolog insulin to Resident #52 subcutaneously by injection. Interview with LPN #6 indicated the scheduled times for the insulin had recently been changed and adjusted because the dining		Physician will be notified of the administration guidelines and orders will be otained to administer Novolog Insulin follwoing accuchecks and accuchecks will be completed 30 minutes prior to meals. C. All Physician orders will be reveiwed by DNS or designee during morning meetings to ensure physician orders for Novolog is administered following accuchecks and the accuchecks will completed within 30 minutes prior to meals.All licensed staff will be educated by the DNS or designee to administer Novolog insulin following accuchecks and accuchecks will be competed within 30 minutes prior to meals following physician orders. Unit managers will monitor the Nurses to ensure accuchecks are completed approximately 30 minutes prior to meals with insulin to follow. A skills check list will be completed by the Unit Managers on all Nurses to ensure they are following the change in accuchecks and administering insulin.D. All new admissions and re-admission physician orders will be reviewed by the DNS or designee using the IDT admission/readmission review tool to ensure resident who receives Novolog insulin will have orders to administer insulin following the accucheck, and the accucheck will be completed with in 30 minutes prior to meals.A check list will be created by the	

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	times had changed. She indicated the insulin had been scheduled for 11:00 A.M., and she was not comfortable giving the insulin so early when the resident ate in the second dining time for the west dining room. However, Resident #52 was not observed to be served his noon meal until 1:25 P.M., almost 1 hour after the Novolog insulin had been administered. The clinical record for Resident #52 was reviewed on 09/08/11 at 9:25 A.M. The resident was noted to have diagnoses, including but not limited to, diabetes. The physician's order for Resident #52 included the following insulin orders: "Novolog (short acting insulin)17 units at noon at in the evening, 20 units at breakfast. Lantus (long acting insulin) 24 units at bedtime and 16 units in the morning. Sliding scale insulin - Novolog 151 - 200 = 2 units, 201 - 250 = 4 units, 251 - 300 = 6 units, greater than 300 = 8 units." Review of the medication instructions for Novolog insulin, obtained from the medication drug book utilized by the facility, titled, Nursing 2011 Drug Handbook, indicated the following: "...give Novolog 5 - 10 minutes before start of meal...." 3.1-35(g)(1)		DNS of all IDDM residents and will completed by the DNS and/or designee monthly on each wing, to check care plans, Physician orders, Mars and Tars to ensure that this deficient practice does not recur. Addendum 10/6/11 F-281: A new blood glucose monitoring tool has been implemented showing the actual time of Insulin administration to ensure that blood sugars are taken within 30 minutes prior to meals and Insulin is administered per Physicians orders and manufacturers instructions. The tool will be used daily for the next 3 months & then monthly x 3 months. If the threshold of 90% is not met; an action plan will be implemented by the DNS/ADNS.	

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F0282 SS=E	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. A. Based on observation, record review, and interview, the facility failed to ensure care plans regarding checking residents for incontinence were followed for 3 of 12 dependent residents observed for incontinence care in a sample of 19 (Residents #41, 64, and 52). In addition, the facility failed to ensure a physician's order regarding removal of an indwelling catheter was followed timely for 1 of 3 residents reviewed for catheters in a sample of 19 (Resident #26). B. Based on record review and interview, the facility failed to provide a physician ordered dietary supplement as ordered for 1 (#88) of 19 residents reviewed for physician's orders. Findings include: A.1. During the initial tour of the facility,	F0282	A. 1. Resident #64 is checked and changed every two hours by staff and provided with incontinence care as needed. 2. Resident #41 bowel incontinence was reevaluated to determine frequency of bowel movements and if a pattern could be established.3. Resident #52 is checked and changed every two hours by staff and provided with incontinence care as needed.4. Resident #26 is administered Promod as ordered by Physician.B. All residents who are incontinent and require assistance with toileting have the potential to be affected by this deficient practice.All residents who are incontinent and require assistance with toileting have the potential to be affected by this deficient practice. Each resident will have a 3 day voiding pattern initiated with 72 hours of admission/readmission and or any change in continence status. The MDS coordinator or designee	10/09/2011

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	conducted on 09/06/11 between 10:50 A.M. - 11:20 A.M., LPN #5, the Unit Manager, indicated Resident #64 was confused, did not ambulate, was pushed by staff in a reclining chair, required total staff assistance for activities of daily living, and was checked for incontinence and changed by staff when needed. On 09/08/11 at 8:30 A.M., Resident #64 was observed in the West dining room being assisted to eat breakfast. She remained in the West dining room until 9:15 A.M., when she was propelled by activity staff to the main dining room for "Sensory" activity. She remained in the main dining room at activities from 9:15 A.M. - 10:45 A.M. At 10:45 A.M., she was pushed to the central unit lounge and placed in front of the television. She remained in the central unit lounge from 10:45 A.M. - 1:04 P.M. At 1:04 P.M., she was pushed directly to the West dining room for lunch. She was not observed to be checked for incontinence at any time from 8:30 A.M. - 1:04 P.M. She was observed to still be in the dining room eating at 1:50 P.M. At 2:01 P.M., Resident #64 was taken from the West dining room to the central lounge. At 2:50 P.M. she was noted to have been placed in her bed and was sleeping. On 09/09/11 at 8:30 A.M., Resident #64		will review the voiding pattern on a daily basis to determine pattern, compliance and continence status. The MDS coordinator or designee will determine if the resident is a candidate for a toileting program. The toilet program will be added to care sheet and the care plan will be updated.A flow sheet with the list of residents who require to be checked and changed every 2 hours for incontinence will be given to Licensed nurses who are assigned to each unit to ensure residents are being checked and changed every two hours. The flow sheet will be updated by the Unit Manager weekly. All New physician orders are read and reviewed in the morning by the IDT (Interdisciplinary Team). The unit managers or designee will review the medication administration record to verify the physician orders have been transcribed accurately to the medicatio administration record. The unit manager or designee will also check the medication cart to ensure the medication is available.Upon completion of the monthly re-writes, the medication administration record will be reviewed by the unit managers to ensure transcription of physician orders have been completed and transcribed to the next month re-writes.C. In-service will be provided to nursing staff on (/27/2011 by DNS or designee on the bladder program policy and	

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	was observed in the West dining room being assisted to eat breakfast. At 9:25, she was taken to the central lounge by staff. She remained in the lounge without any toileting until 10:20 A.M., when she was taken to her room, her ace wraps were changed and she was brought back out to the central lounge at 10:32 A..M. She remained in the lounge until 12:25 P.M., when she was transferred to her bed by LPN #5, the Unit Manager, and CNA # 10 and her brief was changed. Interview with CNA # 10 and LPN #5 indicated Resident #64 was gotten up in the morning by the 3rd shift and it was unclear as to if and/or when day shift had checked the resident for incontinence as CNA #10 was not her assigned CNA. Interview with CNA #7, on 09/09/11 at 12:50 P.M., indicated she was assigned to care for Resident #64 for the day shift. She indicated the Resident was already up at 6:00 A.M., when she started working. She indicated she had not checked Resident #64 for incontinence and/or changed her. She indicated it made her feel bad and she was not trying to ignore some of the residents, but she was just too busy answering call lights and was not able to "get to them." Thus, Resident #64 was not checked for incontinence from 6:00 A.M. - 12: 35 P.M., an over 6 hour time span.		flow record of residents who require check and change every 2 hours will be explained. A pre-post test will be administered to validate the understanding of the education provided.In-service was given on 9/20/11 by the SDC (Staff Development Coordinator) and DNS regarding transcription of physician orders and ensuring medications and supplements are ordered and available.D. The bladder program CQI tool will be completed by the Unit Managers weekly x 4 weeks, monthly x 3 months and quarterly thereafter to ensure residents are on an appropriate toileting program. Unit managers will monitor the voiding check and change flow sheets to ensure compliance.If the threshold is not met on the CQI tools; an action plan will be developed. Date will be submitted to the CQI committee for reveiw and follow up. Any non compliance may result in disciplinary action up to and including termination.The DNS and or designee will be responsible for program compliance. Addendum 10/6/11 F-282: Care plans have been updated for those residents who are totally incontinent & on a toileting program. The bladder CQI monitoring tool will be utilized to monitor those residents who are on a check and change schedule and for residents who are on other toileting programs as well to ensure that all residents	

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	The clinical record for Resident #64 was reviewed on 09/08/11 at 9:05 A.M. The most recent Minimum Data Set (MDS) assessment for Resident #64, completed on 08/08/11, indicated the resident was always incontinent of her bowels and bladder and required extensive staff assistance of two for hygiene and toileting needs. Review of the current health care plan for incontinence, dated as current until 11/21/11, indicated the following intervention: "...check every 2 hours for incontinence..." A.2. During the initial tour of the facility, conducted on 09/06/11 between 10:15 A.M. - 11:00 A.M., LPN #5 indicated Resident #41 was confused, totally dependent on staff for care, was incontinent of his bowels, and was checked and changed as needed. The resident had an indwelling urinary catheter. On 09/07/11 at 8:45 A.M., Resident #41 was observed in the West dining room being assisted with breakfast. At 9:05 A.M., the Resident had been taken in his recliner chair to the West lounge. At 9:35 A.M., he was taken by activity staff to the main dining room for "sensory" activity. At 9:38 A.M., a nursing staff member pushed him from the main dining room to		are being toileted according to their care plans. If the threshold of 90% is not met then an action plan will be written/implemented by the DNS & or designee. A physician order transcription CQI monitoring tool will be used weekly x 4 weeks, monthly x 2 months, then quarterly thereafter to ensure all physicians orders are followed through with in a timely manner. If the threshold of 90% is not met; an action plan will be written/implemented by the DNS and or designee.	

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	his room to "check his temperature." At 9:40 A.M., he was taken back to the main dining room for activities. He remained in the main dining room at activities from 9:40 A.M. - 11:15 A.M., when he was pushed back to the central unit lounge. He remained in the central unit lounge from 11:15 A.M. - 1:15 P.M., when he was pushed to the West dining room for lunch. On 09/09/11 at 8:30 A.M., Resident #41 was observed in the West dining room being assisted with breakfast. He was pushed to the central unit lounge at 9:30 A.M. He was taken to his room and given medications at 9:40 A.M. and brought back out to lounge. He remained in his reclining chair in the central unit lounge until 1:10 P.M., when he was taken to his room and checked for incontinence. The clinical record for Resident #41 was reviewed on 09/07/11 at 1:20 P.M. The most recent MDS assessment for Resident #41 was completed on 08/1/11, and indicated Resident #41 required the extensive staff assistance of two for mobility and personal hygiene needs, and was occasionally incontinent of his bowels. Although the previous MDS assessment, completed on 05/13/11, indicated the resident was always incontinent of his bowels.			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETZ NURSING HOME	116 BETZ RD AUBURN, IN46706

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The current health careplans for Resident #41, current through 11/02/11 indicated a plan to address the resident's bowel incontinence by checking him every 2 hours for incontinence.

A.3. Resident #52's record was reviewed 9/8/2011 at 9:25 a.m. Resident #52's diagnoses included but were not limited to diabetes, dementia and osteoporosis.

During initial tour on 9/6/2011 at 10:50 a.m., SSD #3 indicated Resident #52 wore Depends (incontinent brief) as indicated on the CNA assignment sheet and was checked and changed every 2 hours.

A current care plan for Resident #52, dated 11/09/2010, indicated to assist with incontinence care as needed. The care plan did not include checking and changing.

The most recent Minimum Data Set, dated 7/22/2011, indicated Resident #52 was totally incontinent.

During a continuous observation on 9/8/2011 between 8:15 a.m. and 1:29 p.m., Resident #52 was observed in the West dining room eating breakfast from 8:15 a.m. to 9:15 a.m. At 9:15 a.m., Resident #52 was taken to the Central

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	resident lounge until 9:20 a.m. At 9:20 a.m., Resident #52 was taken to an activity in the main dining area until 10:50 a.m. At 10:50 a.m., Resident #52 was taken to the Central resident lounge until 11:17 a.m. At 11:27 a.m., LPN #9 took Resident #52 to his room to check a blood sugar. Resident #52 was not toileted at that time. At 11:37, Resident #52 was returned to the Central resident lounge where he remained until being taken to room by LPN #9 at 1:00 p.m. Resident #52 was returned to the Central lounge at 1:10 p.m., after receiving his insulin, but without being toileted or checked. Resident #52 remained in the Central resident lounge until he was taken to the West dining area at 1:29 p.m. Resident #52 was not checked or changed during this observation of 5 hours and 15 minutes. During a continuous observation on 9/9/2011 between 8:30 a.m. and 1:25 p.m., Resident #52 was observed in the West dining area eating breakfast between 8:30 a.m. and 9:25 a.m. Resident #52 was then in the Central resident lounge between 9:25 a.m. and 10:17 a.m. At 10:17 a.m., CNA #10 and CNA #11 assisted Resident #52 to lay down in his room. Resident #52 was not toileted or checked. Between 10:17 a.m. and 12:40 a.m., Resident #52 was resting in his			

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	room. LPN #9 entered Resident #52's room at 12:30 p.m., and checked his blood sugar. Resident #52 was not checked or changed at that time. At 12:40 p.m., CNAs # 10 and #11 checked Resident #52 and changed his brief prior to getting him up for lunch. Resident #52 was not checked or changed for this observation of 4 hours and 10 minutes. A.4. During the initial tour of the facility, conducted on 09/06/11 from 10:50 A.M. - 11:20 A.M., LPN #5 indicated Resident #26 had recently been hospitalized, was confused at times, required extensive staff assistance for daily living needs, and had an indwelling urinary catheter. LPN #5 indicated the catheter had to be reinserted recently after a failed attempt to remove it. The clinical record for Resident #26 was reviewed on 09/07/11 at 10:20 A.M. A physician's order, dated 08/29/11, indicated the facility was to discontinue the indwelling catheter on 09/02/11. However, review of nursing progress notes, from 09/02/11 - 09/05/11, indicated the catheter was not removed until 09/05/11 at 8:00 A.M. Interview with LPN #5, the Unit Manager, on 09/07/11 at 12:15 P.M., indicated she was not working on 09/02/11 and even though there was a note left for the staff, the order			

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	was "missed" and not completed until 09/05/11. B.1. Review of Resident #88's clinical record on 9/7/11 at 9:30 A.M., indicated a physician's order was received on 8/31/11 at 1:00 P.M., for Promod, 1 ounce by mouth twice daily to increase protein levels to help heal open areas and for decreased Prealbumin level. On 8/31/11 at 7:00 P.M., the resident received Promod as ordered. The resident did not receive Promod again until 9/4/11 at 7:00 P.M. Resident #88 missed Promod as ordered on 9/1/11 at 9:00 A.M. and 7:00 P.M.; 9/2/11 at 9:00 A.M. and 7:00 P.M.; 9/3/11 at 9:00 A.M. and 7:00 P.M.; 9/4/11 at 9:00 A.M.. An interview with RN #2 on 9/7/11 at 11:15 A.M., indicated the physician's order for the Promod was not transferred from the August Medication Administration Record (MAR) to the September MAR until 9/4/11. 3.1-35(g)(2)			

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F0312 SS=D	A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview, the facility failed to ensure residents dependent for care were provided incontinence management for 3 of 12 residents reviewed with incontinence in a sample of 19. (Resident #64, 41 and 52) Findings include: 1. During the initial tour of the facility, conducted on 09/06/11 between 10:50 A.M. - 11:20 A.M., LPN #5, the Unit Manager, indicated Resident #64 was confused, did not ambulate, was pushed by staff in a reclining chair, required total staff assistance for activities of daily living, and was checked for incontinence and changed by staff when needed. On 09/08/11 at 8:30 A.M., Resident #64 was observed in the West dining room being assisted to eat breakfast. She remained in the West dining room until	F0312	A. 1. Resident #64 is checked and changed every two hours by staff and provided with incontinence care as needed. 2. Resident #41 bowel incontinence was reevaluated to determine frequency of bowel movements and if a pattern could be established.3. Resident #52 is checked and changed every two hours by staff and provided with incontinence care as needed.B. All residents who are incontinent and require assistance with toileting have the potential to be affected by this deficient practice.Each resident will have a 3 day voiding pattern initiated with 72 hours of admission/readmission and or any change in continence status. The MDS coordinator or designee will review the voiding pattern on a daily basis to determine pattern, compliance and continence status. The MDS coordinator or designee will determine if the resident is a candidate for a toileting program. The toilet program will be added to care sheet and the care plan will be updated.A flow sheet with the list	10/09/2011

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	9:15 A.M., when she was propelled by activity staff to the main dining room for "Sensory" activity. She remained in the main dining room at activities from 9:15 A.M. - 10:45 A.M. At 10:45 A.M., she was pushed to the central unit lounge and placed in front of the television. She remained in the central unit lounge from 10:45 A.M. - 1:04 P.M. At 1:04 P.M., she was taken directly to the West dining room for lunch. She was not observed to be checked for incontinence at any time from 8:30 A.M. - 1:04 P.M. She was observed to still be in the dining room eating at 1:50 P.M. At 2:01 P.M., Resident #64 was taken from the West dining room to the central lounge. At 2:50 P.M., she was noted to have been placed in her bed and was sleeping. On 09/09/11 at 8:30 A.M., Resident #64 was observed in the West dining room being assisted to eat breakfast. At 9:25 A.M., she was pushed to the central lounge by staff. She remained in the lounge without any toileting until 12:35 P.M., when she was transferred to her bed by LPN #5, the Unit Manager and CNA # 10 and her brief was changed. Interview with CNA # 10 and LPN #5 indicated Resident #64 was gotten up in the morning by the 3rd shift and it was unclear as to if and/or when day shift had checked the resident for incontinence as		of residents who require to be checked and changed every 2 hours for incontinence will be given to Licensed nurses who are assigned to each unit to ensure residents are being checked and changed every two hours. The flow sheet will be updated by the Unit Manager weekly. C. In-service will be provided to nursing staff on (/27/2011 by DNS or designee on the bladder program policy and flow record of residents who require check and change every 2 hours will be explained. A pre-post test will be administered to validate the understanding of the education provided.D. The bladder program CQI tool will be completed by the Unit Managers weekly x 4 weeks, monthly x 3 months and quarterly thereafter to ensure residents are on an appropriate toileting program. Unit managers will monitor the voiding check and change flow sheets to ensure compliance.If the threshold is not met on the CQI tools; an action plan will be developed. Date will be submitted to the CQI committee for reveiw and follow up. Any non compliance may result in disciplinary action up to and including termination.The DNS and or designee will be responsible for program compliance.	

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	CNA #10 was not her assigned CNA. Interview with CNA #7 on 09/09/11 at 12:50 P.M., indicated she was assigned to care for Resident #64 for the day shift. She indicated the resident was already up at 6:00 A.M., when she started working. She indicated she had not checked Resident #64 for incontinence and/or changed her. She indicated it made her feel bad and she was not trying to ignore some of the residents, but she was just too busy answering call lights and was not able to "get to them." Thus, Resident #64 was not checked for incontinence from 6:00 A.M. - 12:35 P.M., an over 6 hour time span. The clinical record for Resident #64 was reviewed on 09/08/11 at 9:05 A.M. The most recent Minimum Data Set (MDS) assessment for Resident #64, completed on 08/08/11, indicated the resident was always incontinent of her bowels and bladder and required extensive staff assistance of two for hygiene and toileting needs. Review of the current health care plan for incontinence, dated as current until 11/21/11, indicated the following intervention: "...check every 2 hours for incontinence...." 2. During the initial tour of the facility, conducted on 09/06/11 between 10:15			

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	A.M. - 11:00 A.M., LPN #5 indicated Resident #41 was confused, totally dependent on staff for care, was incontinent of his bowels, and was checked and changed as needed. The resident had an indwelling urinary catheter. On 09/07/11 at 8:45 A.M., Resident #41 was observed in the West dining room being assisted with breakfast. At 9:05 A.M., the resident had been pushed in his recliner chair to the West lounge. At 9:35 A.M., he was taken by activity staff to the main dining room for "sensory" activity. At 9:38 A.M., a nursing staff member pushed him from the main dining room to his room to "check his temperature." At 9:40 A.M., he was taken back to the main dining room for activities. He remained in the main dining room at activities from 9:40 A.M. - 11:15 A.M., when he was pushed back to the central unit lounge. He remained in the central unit lounge from 11:15 A.M. - 1:15 P.M., when he was pushed to the West dining room for lunch. On 09/09/11 at 8:30 A.M., Resident #41 was observed in the West dining room being assisted with breakfast. He was pushed to the central unit lounge at 9:30 A.M. He was taken to his room and given medications at 9:40 A.M., and brought			

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	back out to lounge. He remained in his reclining chair in the central unit lounge until 1:10 P.M., when he was taken to his room and checked for incontinence. The clinical record for Resident #41 was reviewed on 09/07/11 at 1:20 P.M. The most recent MDS assessment for Resident #41 was completed on 08/1/11, and indicated Resident #41 required the extensive staff assistance of two for mobility and personal hygiene needs, and was occasionally incontinent of his bowels. Although the previous MDS assessment, completed on 05/13/11, indicated the resident was always incontinent of his bowels. The current health careplans for Resident #41, current through 11/02/11 indicated a plan to address the resident's bowel incontinence by checking him every 2 hours for incontinence. 3. Resident #52's record was reviewed 9/8/2011 at 9:25 a.m. Resident #52's diagnoses included but were not limited to diabetes, dementia and osteopath. During initial tour on 9/6/2011 at 10:50 a.m., SSD #3 indicated Resident #52 wore Depends (incontinent brief) as indicated on the CNA assignment sheet and was			

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	checked and changed every 2 hours. A current care plan for Resident #52, dated 11/09/2010, indicated to assist with incontinence care as needed. The careplan did not include how often to check and change. The most recent Minimum Data Set, dated 7/22/2011, indicated Resident #52 was totally incontinent. During a continuous observation on 9/8/2011 between 8:15 a.m. and 1:29 p.m., Resident #52 was observed in the West dining room eating breakfast from 8:15 a.m. to 9:15 a.m. At 9:15 a.m., Resident #52 was taken to the Central resident lounge until 9:20 a.m. At 9:20 a.m., Resident #52 was taken to an activity in the main dining area until 10:50 a.m. At 10:50 a.m., Resident #52 was taken to the Central resident lounge until 11:17 a.m. At 11:27 a.m., LPN #9 took Resident #52 to his room to check a blood sugar. Resident #52 was not toileted at that time. At 11:37, Resident #52 was returned to the Central resident lounge where he remained until being taken to room by LPN #9 at 1:00 p.m. Resident #52 was returned to the Central lounge at 1:10 p.m., after receiving his insulin, but without being toileted or checked. Resident #52 remained in the			

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	Central resident lounge until he was taken to the West dining area at 1:29 p.m. Resident #52 was not checked or changed during this observation of 5 hours and 15 minutes. During a continuous observation on 9/9/2011 between 8:30 a.m. and 1:25 p.m., Resident #52 was observed in the West dining area eating breakfast between 8:30 a.m. and 9:25 a.m. Resident #52 was then in the Central resident lounge between 9:25 a.m. and 10:17 a.m. At 10:17 a.m., CNA #10 and CNA #11 assisted Resident #52 to lay down in his room. Resident #52 was not toileted or checked. Between 10:17 a.m. and 12:40 a.m., Resident #52 was resting in his room. LPN #9 entered Resident #52's room at 12:30 p.m., and checked his blood sugar. Resident #52 was not checked or changed at that time. At 12:40 p.m., CNAs # 10 and #11 checked Resident #52 and changed his brief prior to getting him up for lunch. Resident #52 was not checked or changed for this observation of 4 hours and 10 minutes. 3.1-41(a)(2)			

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F0314 SS=G	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review and interview, the facility failed to evaluate the use of an immobilizer and develop care plans to prevent the development of pressure ulcers for one of four residents (#88) reviewed for pressure ulcers in a sample of 19. Findings include: Review of Resident #88's clinical record on 9/7/11 at 9:30 A.M., indicated the resident was admitted to the facility on 10/29/09 and had diagnoses including, but not limited to, congestive heart failure, diabetes mellitus, diffuse cerebral atrophy. The record indicated on 8/9/11, the resident had a fracture of her left fibula. A physician's order from 8/11/11 indicated	F0314	A. Resident #88 no longer resides in the facility.B. All residents who require an immobilizer have the potential to be affected by this deficient practice. All resident care plans will be audited to ensure that all residents who are identified as being at risk for skin breakdown will have a care plan developed. Resident care plans will be reviewed and updated by the IDT one time per week according to the MDS schedule fo rthose residents who have had an admission, annual, significant change, quarterly, end of therapy or Medicare MDS completed at (minimum of every 90 days or every 30 days if receiving Medicare A).C. Resident care plans will be reviewed and updated by the IDT one time per week according to the MDS	10/09/2011

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	the resident was to be non weight bearing for four weeks for her left lower extremity and was to wear an immobilizer at all times and may remove for showers. An interdisciplinary team progress note from 8/22/11 indicated the resident had two areas of skin concerns: "Area #1 measures 5.8 centimeters (cm) x 8.7 cm with depth of 0.1 cm-coccyx and left buttocks." "Area #2 is left lateral head of fibula-Area is serous filled intact blister measuring 3.0 cm x 1.8 cm." During an observation of the wounds on 9/8/11 at 9:45 A.M., the Stage II pressure ulcer on the left lower extremity, below the left outer knee was approximately 3.0 cm x 1.5 cm blister without fluid, skin intact. The second Stage II pressure ulcer on the coccyx was approximately 2.0 cm x 0.3 cm with a depth of less than 0.1 cm. The wound was pink and without drainage. Review of the resident's health care plan, dated 12/10/10, indicated the resident was at risk for skin breakdown due to limited mobility, diabetes mellitus, atrial fibrillation, hypothyroidism and incontinence. Approaches to be used included: turn and reposition at least every 2 hours; incontinent care as needed using peri		schedule for those residents who have had an admission annual, significant change, quarterly, endo fo therapy or Medicare MDS completed at (a minimum of every 90 days or every 30 days if receiving Medicare A). All residents who have potential for developing decubitus ulcers, will be reveiwed weekly by IDT to determine need, intervention appropriateness. Unit managers will round daily to assure interventions are in place per care plan and CNA assignment sheets.D. A care plan reveiw CQI tool will be completed by the MDS coordinator to ensure that care plans are reveiwed and reflect the resident weekly x 4 weeks, monthly x 2 months and then quarterly thereafter. If the threshold is not met; an action plan will be developed. Date will be submitted to the CQI committee for reveiw and follow up. The DNS or designee will be responsible for the program compliance.	

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	155694	A. BUILDING 00 B. WING	09/09/2011

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BETZ NURSING HOME	116 BETZ RD AUBURN, IN46706

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wash and moisture barrier; assess and document skin condition weekly and as needed; encourage resident to eat at least 75% of meals; pressure reducing/redistribution cushion in chair/wheelchair; preventative treatment as ordered.

On 8/18/11, a significant change Minimum Data Set (MDS) assessment was completed on the resident due to the fractured fibula on 8/9/11. The MDS of 8/19/11 indicated a decrease in the range of motion for the left lower body.

On 8/25/11, following the development of the two pressure ulcers, the facility started a new health care plan for risk for skin breakdown due to decreased mobility from recent fractured distal femur, diabetes mellitus, atrial fibrillation, hypothyroidism and incontinence.

An interview with the Director of Nursing (DN) on 9/9/11 at 8:50 A.M., indicated she had talked with the wound nurse who indicated the resident was active in attending activities the day after the fracture on 8/9/11 and the resident was able to change positions independently. She indicated the resident already had a wheelchair cushion and didn't add any other interventions after the fall and the use of the immobilizer for the left lower

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	extremity. The DN did not have any other information why the health care plan for risk for pressure ulcers was not updated after the fracture on 8/9/11 until after the development of the pressure ulcers, first noted on 8/22/11. 3.1-40(a)(1)			
F0323 SS=G	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review, the facility failed to ensure a resident was transferred safely and in accordance with care plan interventions for 1 of 8 residents reviewed for falls in the sample of 19. This resulted in the resident sustaining an upper leg fracture. (Resident #88) Findings include: Review of Resident #88's clinical record on 9/7/11 at 9:30 A.M, indicated the resident was admitted to the facility on 10/23/09 and had diagnoses including, but not limited to, diffuse cerebral atrophy, glaucoma, congestive heart failure and	F0323	A. Resident #88 no longer resides in this facility.CNA #8 was provided with education on transferring and was given a written warning.B. All residents that experience a fall have the potential to be affected by this deficient practice. All staff in service on fall prevention, reading and implementing what is written on the CNA assignments was given by the DNS on 9/9/2011.C. All falls will be discussed by the IDT during am meeting to determine other possible interventions to prevent falls. The fall circumstance report will be reviewed by the team. A CQI form will be completed for	10/09/2011

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	atrial fibrillation. Review of a "Fall Circumstance Report" from 8/8/11 at 11:30 A.M., indicated Resident #88 was using the toilet with CNA #8 present and when the CNA went to put the resident back in her wheelchair, the wheelchair rolled back. The CNA lowered the resident to the floor. No injuries were noted during the initial exam after the fall. The nurse's notes of 8/9/11 at 2:30 P.M., indicated the resident was complaining of pain in her left knee. At 4:00 P.M., the physician was notified of left knee swelling and complaints of pain and received instructions to monitor area for increased pain and swelling. At 5:00 P.M., a physician's order was received to have an x-ray of the left knee. At 8:30 P.M., the x-ray results indicated the resident had a fracture of left distal femur. Review of Resident #88's health care plan from 12/10/10 indicated the resident required extensive assist of two for transferring and toileting. Review of the undated initial facility fax incident reporting form included under preventative measures taken, CNA #8 was given a written warning and one on one training with staff development educator		necessary follow up The care plan will be reviewed and updated as necessary. CNA assignment sheets will be updated as well. Unit managers will round each morning to make sure all fall interventions are in place in accordance with the care plans and CNA assignment sheets.d. Nurse Managers will complete nurse rounds daily to ensure staff is providing care according to residents care plans. A fall Management CQI tool will be completed by the DNS to ensure the compliance with fall program weekly x 4 weeks then monthly x 2 months then quarterly thereafter. If the CQI threshold is not met; an action plan will be developed. Date will be submitted for reveiw and follow up. The DNS will be responsible for the program compliance and any non compliance may result in disciplinary action to including termination.	

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	on proper transferring. Review of the employee communication form included the employer statement indicating CNA #8 transferred Resident #88 by herself when the resident required a two person assistance. 3.1-45(a)(2)			
F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review, and interview, the facility failed to ensure the facility policy and procedure regarding safe food handling was followed. This potentially affected 71 of 71 residents receiving a regular diet and 14 of 14 residents receiving a mechanical ground diet. A total of 85 of the population of 93 residents were potentially affected. Finding includes: On 09/06/11 at 11:50 A.M., Cook #8 was observed serving the noon meal. The cook had donned a pair of gloves, then was noted to touch the outside of the microwave, the microwave handle, the outside of a pan of shredded cheese, the handle to a drawer, before she proceeded	F0371	A. Cook # 8 provided with 1:1 education by the Dietary Manager regarding Policy/procedure on handling food.B. All residents receiving meals from the kitchen have the potential to be affected by this deficient practice. C. An in-service will be given on 9/26/11 regarding Proper use of gloves and hand washing, along with review of policy /procedure.D. The Dietary Manager will monitor the serving line staggering meals daily x 4 weeks and then weekly x 4 weeks the monthly thereafter to assure proper food handling is maintained.	10/09/2011

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	to serve the meal. Without changing her gloves, Cook #8 was noted to touch soft tortilla shells with her gloved hands and place them onto plates. In addition, she was noted to use a small bowl and her left hand to directly touch corn chips prior to placing them onto resident plates. The small bowl, which was being utilized to scoop corn chips was handled with her right gloved hand on the outside and then the whole bowl was dropped back on top of the supply of corn chips. Review of the facility's policy and procedure, titled "Food Handling Policy", dated 05/06 and presented on 09/09/11 as the current policy by the Administrator, indicated the following: "1. Food employees (any individual working with food, food equipment or utensils, or food contact surfaces) will clean their hands and exposed portions of their arms before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and :a) After touching bare human body parts and other than clean hands and clean,exposed portions of arms; b) After coughing, sneezing, using handkerchief or disposable tissue; c) After handling soiled surfaces, equipment or utensils; d) During food handling, as often as necessary to remove soiled and			

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	contamination and to prevent cross-contamination when changing tasks; e) directly before touching ready-to-eat food or food-contact surfaces; and f) After engaging in other activities that contaminate the hands..." Interview with the Food Service Supervisor, employee #9, on 09/06/11 at 12:30 P.M., regarding the concern indicated the cook could have used tongs to manipulate the tortillas and a "spoodle" to scoop the corn chips to prevent her contaminated hands from touching the food directly. 3.1-21(i)(2)			